CASE STUDY

Making Patient Flow a Leadership Responsibility

A SOUTHEAST TEXAS COMMUNITY HOSPITAL

ELITE HOSPITAL PARTNERS

Physician turnover, low morale, and patient-flow problems affected this department. EHP built a dedicated physician team while addressing the arrival routines, boarding, nursing capacity, and service delays that shaped the patient experience. Active site leadership connected encounter-level review with hospital-wide action.

PROTECT TRUE PULL-TO-FULL AT ARRIVAL

Patients were to bypass the traditional triage queue when appropriate treatment space was available in the back. Quick triage identified the essential acuity and placement information; the rest of intake could occur around care. EMS crews were to connect with the charge nurse and move patients into care before registration. When registration staff interrupted that sequence, the medical director formally escalated the problem to registration leadership.

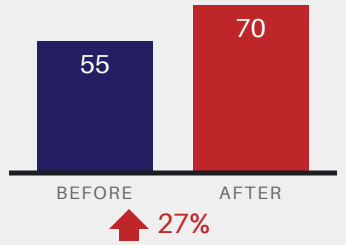
KEEP THE FRONT END WORKING UNDER PRESSURE

EHP ended the overuse of diversion during busy periods, adopting a no-diversion approach to routine saturation. Front-end evaluation, workup, treatment, and disposition continued when the back was full. Reports examined how triage, treatment, and discharge tasks competed for limited front-end staff. Leadership addressed those demands so the response to saturation was an active care process rather than turning away incoming patients.

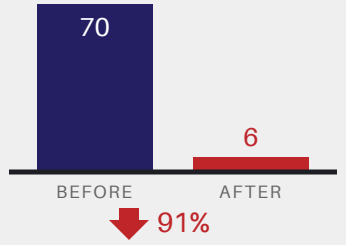
USE ENCOUNTER REVIEW TO IDENTIFY THE NEXT ACTION

The medical director reviewed prolonged low-acuity encounters by provider, followed up for explanations, and examined triage accuracy. Reports linked ED holds and nursing availability with treatment-space access, length of stay, and walkouts. The work distinguished delays in medical decisions from delays in completing orders, giving instructions, or physically moving patients.

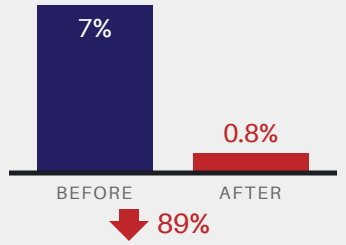
Daily ED visits



Door to physician (min)



Left without being seen



PROVIDER IN TRIAGE

EHP does not use a provider-in-triage (PIT) model to improve metrics. Although there are good PIT models, for the most part PIT is a time stamp. EHP fixes the process, and the metrics follow.

Sustaining the process and measuring the results

REINFORCE THE PROCESS REPEATEDLY

Leadership tracked departures from direct bedding and brought recurring barriers into ED flow and joint operations meetings. Discussions addressed staffing deployment, bed assignment, inpatient discharge, and movement to the floor. Weekly reports and CEO meetings preserved unresolved issues for follow-up instead of allowing each meeting to restart the same conversation.

CONNECT INPATIENT FLOW WITH ED CAPACITY

Direct bedding depends on treatment space becoming available. The medical director brought inpatient discharge timing, bed assignment, and delays in moving admitted patients to the floor into throughput discussions. Reports examined how holds consumed ED rooms and nursing resources, limiting the ability to bring new arrivals into the back. These findings directed attention to the specific handoffs that needed improvement.

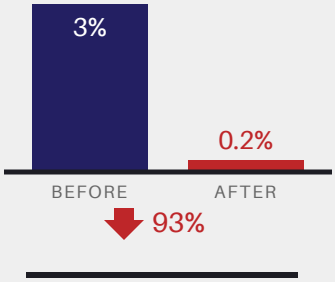
FOLLOW DIAGNOSTIC DELAYS TO THEIR SOURCE

Leadership reviewed lab and imaging delays, equipment downtime, communication failures, and image-interpretation turnaround. Review traced work from specimen collection to results and from imaging request to interpretation. Clearer interruption notices helped physicians adjust care. The aim was parallel progress through testing and treatment, with ownership of the next action.

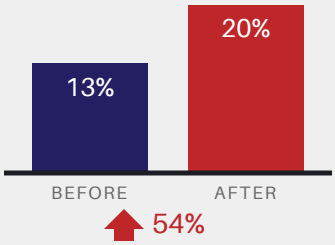
STANDARDIZE EMS HANDOFFS AND PHYSICIAN PRACTICE

EHP set an EMS wall-time goal under 10 minutes, using direct bedding and provider engagement at handoff. Continued acceptance during busy periods reinforced access for crews. The full-time physician team received documentation feedback and customized AI scribe support. Leadership followed chart deficiencies and critical-care documentation while tracking unresolved staffing and boarding barriers.

Left against medical advice



Encounters resulting in admission



Operating model

Rooms available in the back

True pull-to-full: bypass the triage queue and move patients into appropriate available treatment space.

Initial acuity assessment

Quick triage: obtain the essentials needed for safe placement; complete remaining steps around care.

Back of the ED saturated

Continue receiving patients without diversion for routine saturation; activate front-end evaluation, treatment, and disposition.

REPORTED OUTCOMES

MEASURE	BEFORE	AFTER	CHANGE
Average daily ED visits	55	**70**	**+27%**
Door-to-physician time	70 min	**6 min**	**−91%**
Left without being seen	7%	**0.8%**	**−89%**
Left against medical advice	3%	**0.2%**	**−93%**
ED encounters resulting in admission	13%	**20%**	**+54%**

Before figures reflect the department prior to the changes described. After figures reflect a later period under EHP management. Individual measures improved at different points. LWBS and AMA are separate measures. EMS wall time under 10 minutes was a goal, not a measured result supplied here. Results are descriptive; hospital-wide constraints remained.

